

Arizona State Hospital Annual Report

FY 1985 - 1986

ARIZONA DEPARTMENT OF HEALTH SERVICES
dhs

ARIZONA STATE HOSPITAL

ANNUAL REPORT

FISCAL YEAR 1985-86

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INTRODUCTION

Arizona State Hospital (ASH), a state-supported facility operating at 2500 East Van Buren, Phoenix, Arizona, provides inpatient psychiatric care and treatment for state residents who are suffering from severe mental and emotional illnesses and disorders. It is the mission of Arizona State Hospital to develop and enhance the strengths, abilities and interest of patients enabling them to return to their families and communities.

This report describes the work done in the clinical/administrative and physical plant areas, the types of patients in ASH treatment programs, the treatment programs, treatment methods, staffing, the condition of the physical plant, the ASH Financial Summary for FY 1985-1986 and recommendations for improvements.

In FY 1985-1986, there was a stabilization in the patient census. The census was 498 at the beginning of the year and was at 492 at the end of the year. In the two previous years the census grew from 342 to 493, an increase of 44.2 percent. That increase coincided with the implementation of a more lenient commitment law in July of 1983, and subsequent liberalization of the law again in August, 1985.

The statutory changes do seem to have contributed to the rise in the ASH census between FY 1983-1984 and FY 1985-1986, but perhaps not to the degree that many anticipated. Court-ordered commitments accounted for 60 percent of total commitments in FY 1982-1983, 63 percent in FY 1983-1984, and 80 percent in FY 1985-1986.

The Department of Health Services has taken steps to ensure that involuntary commitments to ASH are appropriate. A psychiatrist is under contract to the Department to review petitions for court ordered treatment under Title 36 and attend commitment hearings when intervention is indicated. Intake procedures have been improved at ASH. Admissions are reviewed daily for appropriateness of referrals.

Another factor that contributed to the increasing ASH census was the growth in

the number of patients whose illnesses are so severe as to require long stays in the State Hospital. Also, Court actions are committing patients for longer stays. Many of the longer term patients are housed in the Continued Care Program units. At the close of FY 1983-1984, 135 patients resided in these units; by the end of FY 1985-1986, 172 patients resided in these units, an increase of 27 percent. A possible result of the change in admission characteristics on the census was a rise in the median length of stay[1] (see Table 2).

An indepth continuing analysis of lengths of stay is being conducted by the Hospital. It may be more statistically relevant to use the mean length of stay.[2] Furthermore, an examination of patients with lengths of stay greater than one year showed that 49 patients accounted for the abnormally high lengths of stay. The 49 patients had a combined length of stay of 58,063 days or an average of 1,185 days or 3.2 years per patient. Including the lengths of stay for these patients in the calculation increases the Hospital's overall average. As these long term patients are discharged and placed in community settings, they will continue to have an impact in the overall length of stay.

[1]The median length of stay is the arithmetic midpoint or 50 percentile. The median length of stay means that 50 percent (one half) of the patients were discharged by this point in time.

[2]The arithmetic mean is calculated by adding the total length of stay for each patient discharged and dividing this total length of stay by the total number of patients discharged.

WORK DONE

Administrative/Clinical

The focus of the Hospital Administration's efforts during FY 1985-1986 was to strengthen and revitalize all facets of Hospital operations. Major emphasis was placed on analysis, planning and development. This effort revolved around several fundamental concepts which served as the philosophical core for all changes implemented. One of the major concepts is that the clinical efforts at the Hospital should emphasize patient care and therapy supported by the nursing care and social rehabilitation functions. In the provision of services, the service delivery should be oriented in the best interest of the patients over administrative convenience. Functions should be conceptualized according to the most appropriate level of control with decision-making occurring at all levels of the organization. Employees should be afforded the best possible opportunities for professional growth. A comprehensive system of checks and balances is essential in the planning and control of the Hospital as as efficient organization. Each of the accomplishments outlined in this section is based on these tenets.

In October, 1985, a strong, hospital-wide program evaluation, quality assurance and utilization review program was established through Program Planning and Evaluation Services. The monitoring systems being developed apply to all clinical, administratiave, and support programs and services at the Hospital. The systems will provide a comprehensive set of checks and balances and includes the functions of utilization review, audits, patient care monitoring, risk management and trend analysis. At the time of the JCAH survey in February, 1986, the major structural components had been developed, e.g., Medical Staff Bylaws, working drafts of the Quality Assurance (QA), Utilization Review (UR), Risk Management (RM), and Management Information System (MIS) components which comprise the Quality Assurance System (QAS).

Much progress has been made towards operationalizing the hospital-wide QAS in

the succeeding months following the survey. A multi-directional approach has been successful toward integrating and consolidating program and service monitoring of performance relative to Arizona State Hospital standards and desired outcomes. The multi-directional approach has been to structure or restructure with attention paid to the expected processes and eventual outcomes of the structuring or restructuring.

The concept of this approach is participatory rather than autocratic. By involving the programs and services in the development of the QAS there is greater opportunity for changing staff attitudes and behaviors while making changes that improve patient care.

Central to the participatory concept is the idea of monitoring and problem solving at the lowest (first) level of involvement. Patient care monitoring is the first level of involvement in the QAS. The monitoring is conducted by multi-disciplinary members of each treatment program's treatment team. Each treatment program is required to maintain a problem log for use in identifying real or potential problems, tracking problems and providing follow-up.

The patient care monitoring (PCM) file and problem log become the key sources of information that begins the cyclic process of the QAS. The PCM file is used to identify unresolved individual patient problems and is used to identify problems affecting the treatment program population as a whole. The treatment program medical director uses the PCM file to formulate his or her report to the Utilization Review Committee (URC). Issues unresolved by the URC are then reported to the Quality Assurance Committee (QAC) by the chairman of the URC. The QAC takes appropriate steps as indicated by either taking action and monitoring follow-up or making recommendations to the Superintendent for final disposition.

The current focus of development for the ASH QAS has been on the clinical treatment programs. However, all programs and services at ASH will be involved in the QAS. What follows is a list of the activities, accomplishments and projected completion dates of the multi-directional approach used to develop the QAS.

Completed

- Risk Management Ad Hoc Committee established.
- Reorganization of Medical Records and establishment of Data Control (to ensure completeness and accuracy of medical records.
- Incomplete medical record tracking system.
- Medical Activity Reporting System (MARS) for: systematic tracking and accounting of physician services, contract compliance, appointment and reappointment and clinical monitoring.
- Case review format, for comprehensive objective and uniform method/format for patient case reviews.
- Program Evaluation Methodology, for objective comprehensive quantifiable format for hospital-wide programs and services.
- Quality Assurance Committee reorganized and operating per Bylaws (March 1986).
- Program/service Quality Assurance Plan format.
- Format integrated into treatment program manuals. (Treatment Program manuals form the basis for the treatment programs. Quality Assurance plan).
- The following services have begun developing a QA Plan utilizing the hospital-wide format - Occupational Therapy, Speech/Language/Hearing, Recreational Therapy, Social Services, Dietary.
- All ASH programs and services are expected to have an operational Quality Assurance Plan by June 1, 1987.

As a result of the analysis of the programs and their relationship to the Quality Assurance system, it was indicated that there was a need to re-evaluate the current organization of the treatment units.

Beginning in May, 1986, the Directors of the Clinical Services and representatives

of the Medical Staff and the Hospital Administration met to determine the best alignment of the sixteen treatment units into programs which could serve patients with sets of similar identified needs. The alignment would: 1) re-emphasize the importance of serving the patient's needs, 2) create a setting where the professional staff could develop expertise in treating specific groups of patient populations, 3) create a management system in which unit or program-specific problems could be handled at the program level, 4) allow resources to be efficiently utilized and coordinated among the units within a program, 5) promote the interaction and utilization of all disciplines as an interdisciplinary treatment team to provide comprehensive treatment, and 6) reinforce the responsibility and involvement of the physicians in the management and provision of clinical care and therapeutic interventions for patients.

The Treatment Programs proposed would be:

TREATMENT PROGRAMS	UNIT
Admissions and Early Discharge	Reception Center Kachina 1 Kachina 2 Transitional Living
Adolescent Treatment	Adolescent Treatment
Behavioral Management	Cholla Juniper 10 Juniper 1
PsychoSocial Rehabilitation	Juniper 6 Granada West
Extended Care	Juniper 2 Juniper 4 Juniper 8
Geropsychiatry	Juniper 3 Juniper 7 Juniper 9 Granada

Each program would be under the direction of a psychiatrist appointed as the Treatment Program Director. The Director would assume the leadership role in the

design and development of the assigned program, direct the activities of the interdisciplinary treatment teams which provide services to the patients and assure the quality of the program. Each interdisciplinary team would be comprised of psychiatrists, medical specialists, psychologists, nurses, social workers, rehabilitation therapists, auxillary clinical staff and others--some of whom may be assigned to more than one program. Patients would be assigned to a treatment program based on their needs and level of functioning.

This alignment of programs was put into effect near the end of FY 1985-1986. Therefore, it will not be reflected in the narrative or statistical sections of this report. Furthermore, as the programs develop and the needs of the patients are more clearly defined, it may become necessary to change the alignment of the treatment wards or the details of each program. The current programmatic alignment of services is considered dynamic with the ability to change and respond to best serve the needs of the patients. The annual report for FY 1986-1987 will contain the details of this change in programs and its effectiveness.

To allow the Hospital to meet the standards of the Joint Commission on Accreditation of Hospitals, the medical staff bylaws were completely rewritten. A major emphasis in the revision was to revitalize the role of the physicians in providing medical leadership. Staff physicians were assigned responsibilities in hospital-wide committees and serve as chairpersons on all medical staff committees.

Personnel functions were centralized in a well staffed personnel department. This resulted in increased recruitment efforts, a vigorous advertising program, improved efficiency in hiring and development of a specialized staff training programs. The turnover rate at Arizona State Hospital was reduced from 30% in FY 1984-1985 to 25% in FY 1985-1986. ASH had one of the highest vacancy rates in 1984-1985 at 30%. The vacancy rate for FY 1985-1986 was a manageable 9%. To overcome problems associated with recruiting qualified staff to fill psychiatric technician positions, a training program

was implemented to develop the necessary skills in personnel with little or no previous training or experience in this area. The Personnel department also serves as an additional opportunity for employees to voice their opinions regarding personnel practices within their disciplines.

To increase the participation of employees in problem solving activities and the decision making process, quality circles have been created. The members of the quality circles are primarily the line staff of the Hospital and the quality circles serve as a forum for the discussion of problems affecting the quality of care and employee morale. The groups are required to make recommendations on the solutions to the problems discussed.

Data and information services are now provided through Program Planning and Evaluation. This organization allows for better utilization of the resources of the data section and the program planning and evaluation staff. One result of this group's efforts is an intensive study into the Hospital's length of stay statistics.

Arizona State Hospital has completed the first phase of modernizing its data information system. The Arizona Department of Health Services has received an additional appropriation of approximately $340,000 to complete Phase II.

At the present time, the data system is relieving the Hospital of the previous manpower intensive system and is meeting more of the needs of patients and staff. The Patient Accounting and Clinical Enquiry system (PACE) has enhanced medical recordkeeping, pharmacy, finance and clinical systems and provides information and analysis to ASH management for program planning and policy development.

The second phase of PACE will enhance clinical, evaluation and ancillary data systems. The second phase will also be designed to provide tracking of ASH patients through community treatment and residential care programs. Furthermore, this phase will integrate mainframe and personal computer activities to provide ASH with more rapid, accurate and indepth analysis of clinical and management data.

Physical Plant

Major improvements in the physical plant at the Arizona State Hospial for FY 1985-1986 included the installation of a 10-foot high fence. This project is 60% complete and provides a safer and more secure environment for both the patients in residence and the surrounding community.

A fire sprinkler system was installed on Juniper 5, a patient treatment unit scheduled to open in early 1987, and throughout the entire Kachina Building. Kachina Building is comprised of the Arizona State Hospital's reception center, patient barber shop, two patient treatment units, adult education, psychology, rehabilitation services and the patient library.

Several units have been remodeled in an effort to relieve overcrowding and improve services. Remodeling of Granada West resulted in the opening of a new patient treatment unit and relieving the overcrowded conditions on some existing units. Work to remodel Juniper 5 for patient use began and the unit is expected to open in early 1987.

Major renovation and remodeling was completed on Juniper 1 to convert its use for the Behavior Management Program. This allowed the transfer of all female patients from Cholla to Juniper 1.

Remodeling on Juniper 3, Kachina 2 and Cholla Hall resulted in increased documentation and charting areas, as well as producing additional space for patient training on Juniper 3.

New bathroom fixtures and equipment were installed in the Juniper 9 bathrooms and restrooms to provide easier access and utilization by the geriatric population served by this unit.

The enclosure of the patios of Juniper building began during this year. These enclosures provided more usuable living space for the patients on ten treatment units.

Improvements including the installation of new equipment were undertaken. New evaporative coolers were installed in both the dietary and the power plant facilities.

New equipment was installed in dietary allowing for the expansion of services needed to meet the needs of both the Arizona State Hospital and the Department of Corrections' facilities located on ASH grounds.

Expanded hot water capacities were needed as Hospital patient levels and laundry demands increased. Improvements and replacements of the boiler pumps that are responsible for the production and distribution of hot water were completed.

TABLE 1

ARIZONA STATE HOSPITAL
Average Monthly Census, Admissions and Discharges
By Type Of Admission

	Avg. Mthly Census	Total Admiss.	1st Admiss.	Re-Admissions	Invol. Commit.	Total Dischgs*
FY 1985-1986						
July	484	34	18	16	30	61
August	465	45	19	26	36	54
September	470	52	24	28	43	48
October	466	52	18	34	35	43
November	484	48	24	24	36	35
December	496	60	29	31	50	43
January	504	45	27	18	39	48
February	506	47	29	18	40	35
March	518	54	27	27	41	53
April	518	57	35	22	51	53
May	500	53	26	27	42	73
June	492	51	25	26	41	58
TOTAL	**492**	**598**	**301**	**297**	**484**	**604**

*Total Discharges are all exits including deaths.

TABLE 2

ARIZONA STATE HOSPITAL
LENGTH OF STAY FOR DISCHARGES*
FY 1983-1984, FY 1984-1985, FY 1985-1986

	FY 1983-84		FY 1984-85		FY 1985-86	
DAYS IN HOSPITAL	**Number**	**%**	**Number**	**%**	**Number**	**%**
Under 7 Days	80	14	45	7	13	2
7 - 13 Days	49	8	27	4	21	4
14 - 20 Days	55	9	31	5	15	3
21 - 30 Days	42	7	50	8	31	5
31 - 60 Days	121	21	128	20	87	15
61 - 90 Days	59	10	85	13	94	16
91 - 180 Days	93	16	149	23	136	24
181 - 365 Days	51	9	80	12	100	18
1 - 5 Years	31	5	41	6	65	11
5+ - Years	7	1	12	2	12	2
TOTAL	**588**	**100%**	**648**	**100%**	**574**	**100%**
MEAN:	146 Days		166 Days		231 Days	
MEDIAN:	48 Days		74 Days		113 Days	

*Discharges do not include deaths but do include all other exits.

TABLE 3

ARIZONA STATE HOSPITAL
ADMISSIONS BY AGE
FY 1985-1986, FY 1984-1985

	FY 1985-86		FY 1984-85	
Age	**Number**	**%**	**Number**	**%**
Under 19	55	9	57	8
19 - 29	185	31	218	31
30 - 39	164	27	189	26
40 - 64	146	25	188	26
65+	48	8	65	9
TOTAL	**598**	**100%**	**717**	**100%**

TABLE 4

ARIZONA STATE HOSPITAL
ADMISSIONS BY SEX
FY 1985-86, FY 1984-85

	FY 1985-86		FY 1984-85	
Sex	**Number**	**%**	**Number**	**%**
Male	333	56	419	58
Female	265	44	298	42
TOTAL	**598**	**100%**	**717**	**100%**

TABLE 5

ARIZONA STATE HOSPITAL
ADMISSIONS BY ETHNICITY
FY 1985-1986, FY 1984-1985

	FY 1985-86		FY 1984-85	
Ethnicity	Number	%	Number	%
White	421	70	531	74
Hispanic	96	16	100	14
American Indian	13	2	9	1
Black	63	11	62	9
Other	5	1	15	2
TOTAL	**598**	**100%**	**717**	**100%**

TABLE 6

ARIZONA STATE HOSPITAL
TOTAL NUMBER AND PERCENTAGE OF ADMISSIONS BY COUNTY
FY 1985-1986; FY 1984-1985 AND
FY 1983-1984

	FY-1983-1984		FY 1984-1985		FY 1985-1986	
County*	Number	%	Number	%	Number	%
Maricopa	472	65	412	57	373	63
Pima	63	9	77	11	62	10
Apache	3	0	5	1	2	0
Cochise	11	1	13	2	2	0
Coconino	12	2	15	2	16	3
Gila	31	4	16	2	11	2
Graham	15	2	14	2	5	1
Greenlee	0	0	0	0	2	0
La Paz	0	0	0	0	0	0
Mohave	8	1	8	1	6	1
Navajo	13	2	19	3	14	2
Pinal	41	6	53	7	31	5
Santa Cruz	2	0	5	1	1	0
Yavapai	26	3	33	5	30	5
Yuma	34	5	47	6	34	6
Out-of-State/ Unknown	0		0		9	2
TOTAL	**731**	**100%**	**717**	**100%**	**598**	**100%**

* County of Admission

TABLE 7

ARIZONA STATE HOSPITAL
ADMISSION RATES PER 100,000 POPULATION BY COUNTY
FY 1982-1983; FY 1983-1984; FY 1984-1985 AND FY 1985-1986

County*	FY 1982-83	FY 1983-84	FY 1984-85	FY 1985-86
Maricopa	18.2	27.0	22.8	20.0
Pima	9.8	10.2	12.3	9.6
Apache	6.2	4.6	9.7	3.5
Cochise	12.6	11.6	14.0	2.0
Coconino	17.3	13.0	17.8	18.1
Gila	71.1	78.7	44.1	28.9
Graham	32.7	61.2	60.3	21.3
Greenlee	8.0	0	0	24.1
La Paz	0	0	0	0
Mohave	14.7	13.1	12.0	7.8
Navajo	20.7	16.8	26.5	18.9
Pinal	28.1	41.1	52.2	30.5
Santa Cruz	12.1	8.1	21.4	3.5
Yavapai	24.1	33.0	39.5	35.8
Yuma	34.8	39.4	54.0	36.8
STATEWIDE RATE	**17.6**	**23.3**	**22.6**	**18.1**

*County of Admission

TABLE 8

ARIZONA STATE HOSPITAL
NUMBER AND PERCENT OF ADMISSIONS
BY DIAGNOSTIC REASON
IN FY 1984-1985 AND FY 1985-1986

	FY 1985-86		FY 1984-85	
DIAGNOSIS GROUPING	**Number**	**%**	**Number**	**%**
Schizophrenic Disorders	228	38	304	42
Affective Psychoses	201	34	202	28
Paranoid States	5	1	4	1
Other Psychoses	6	1	11	2
Neurotic Disorders	14	2	0	0
Senile and Presenile Organic Psychotic Conditions	19	3	38	5
Alcoholic Psychoses	6	1	2	0
Other Organic Mental Disorders	60	10	58	8
Drug Related Disorders	11	2	8	1
Personality Disorders	8	1	16	2
Adjustment Reactions	18	3	17	3
Disturbance of Conduct	5	1	18	3
Mental Illness/Mental Retardation	1	.1	8	1
Alcohol Abuse	0	0	8	1
Other	16	2.9	23	3
TOTAL	**598**	**100%**	**717**	**100%**

TABLE 9

ARIZONA STATE HOSPITAL
NUMBER OF DISCHARGES BY COUNTY AND TYPE OF DISCHARGE
FY 1985-86

	CONDITIONAL DISCH	IP/OP* TRMT	COMPLETE DISCH	UNAUTHORIZED ABSENCE	DEATH**	TOTAL
Maricopa	41	115	206	7	30	399
Pima	5	6	34	1	0	46
Apache	0	0	1	0	0	1
Cochise	0	2	0	0	0	2
Coconino	2	3	16	0	0	21
Gila	3	1	8	0	0	12
Graham	0	0	7	0	0	7
Greenlee	0	0	0	0	0	0
LaPaz	0	1	2	0	0	3
Mohave	0	0	8	0	0	8
Navajo	1	0	7	1	0	9
Pinal	8	1	17	1	0	27
Santa Cruz	0	0	1	1	0	1
Yavapai	2	7	14	0	0	23
Yuma	8	3	6	0	0	17
Out of State	0	0	28	0	0	28
Unknown	0	0	0	0	0	0
TOTAL	**70**	**139**	**355**	**10**	**30**	**604**

*Inpatient/Outpatient Treatment

**The average number of deaths at Arizona State Hospital over the past four years is 25 deaths per year.

TABLE 9A

ARIZONA STATE HOSPITAL
PERCENTAGE OF DISCHARGES BY COUNTY AND TYPE OF DISCHARGE*
FY 1985-1986

	CONDITIONAL DISCH	IP/OP** TRMT	COMPLETE DISCH	UNAUTHORIZED ABSENCE	DEATH	TOTAL
Maricopa	7	19	34	1	5	66
Pima	1	1	6	0.1	0	8
Apache	0	0	0.1	0	0	0.1
Cochise	0	0.3	0	0	0	0.3
Coconino	0.3	0.5	3	0	0	3
Gila	0.5	0.1	1	0	0	2
Graham	0	0	1	0	0	1
Greenlee	0	0	0	0	0	0
LaPaz	0	0.1	0.3	0	0	0.5
Mohave	0	0	1	0	0	1
Navajo	0.1	0	1	0.1	0	1
Pinal	1	0.1	3	0.1	0	5
Santa Cruz	0	0	0.1	0	0	0.1
Yavapai	0.3	1	2	0	0	4
Yuma	1	0.5	1	0	0	3
Out of State	0	0	5	0	0	5
Unknown	0	0	0	0	0	0
TOTAL	**11.2**	**22.6**	**58.5**	**1.3**	**5.0**	**100**

*Percentage errors due to rounding
**Inpatient/Outpatient Treatment

PATIENT DEMOGRAPHICS

The demographic composition of ASH admissions has been stable between FY 1984-1985 and FY 1985-1986 (see Tables 3, 4, and 5). Roughly one-third of the admissions were between 19 and 29 years of age, one-quarter between 29-39 and 40-64, respectively, and one-tenth under 19. The over 65 population declined to eight percent of the admissions. The percentage of admissions that were male declined from almost 60 percent in FY 1983-1984, to 56 percent in FY 1985-1986, a decrease of almost four percent in two years. A one percent decrease was evident from the previous year. The composition of racial and ethnic admissions has also changed significantly. In FY 1983-1984, 77 percent of admissions were white, in FY 1984-1985, 74 percent were white and in FY 1985-1986, 70 percent of admissions were white. Both Hispanic and Black admissions have increased by three percent. The number of American Indian admissions increased one percent.

Not surprisingly, most of the admissions to ASH came from Maricopa County and, to a lesser degree, from Pima County. However, there have been changes in the proportion and rates of patients coming from each county (see Tables 6 and 7). In terms of the proportion of total admissions from each county, a decreasing percentage of ASH admissions reside in Maricopa County. Thus, 65 percent of the admissions came from Maricopa County in FY 1983-1984, while 63 percent came from Maricopa County in FY 1985-1986.

When the population of each county is taken into account by looking at the admission rates per 100,000 population, a somewhat different pattern emerges. Looked at in this fashion, Yuma County has the largest admission rate of any county, 36.8 per 100,000 population in FY 1984-1985. However, these trends will vary significantly each year, especially in the smaller counties. Among other counties with significant numbers of ASH admissions, Yavapai, Pinal, Gila, Greenlee, Graham, Maricopa and Navajo

counties respectively have admission rates in excess of the average statewide rates.

Consistent with the ASH mission of caring for and treating severely disturbed patients, almost three-fourths of the ASH admissions in FY 1985-1986 suffered from severe, functional psychotic conditions (see Table 8). Thirty-eight percent of the admissions suffered from schizophrenic disorders, 34 percent from affective psychosis and two percent from paranoia or other psychoses. An additional 14 percent of the admissions had disorders related to underlying organic causes, with three percent of these patients suffering from dementia.

During FY 1985-1986, 604 patients left ASH, of which 410, or 68 percent, were complete discharges (see Table 9 and 9A). Almost two-thirds, or 66 percent of these exits were to Maricopa County; however, 63 percent of ASH admissions were from Maricopa County. In contrast, eight percent of the discharges were to Pima County, and 10 percent of admissions were from Pima County. No other County received more than six percent of the ASH discharges.

The impact of conditional and inpatient/outpatient discharges and treatment can also be seen on Table 9 and 9A.

TREATMENT PROGRAMS

The Arizona State Hospital is organized by treatment programs. Each treatment program has interdisciplinary teams comprised of psychiatrists, medical specialists, psychologists, nurses, social workers, rehabilitation therapists, auxiliary clinical staff and others--some of whom are assigned to more than one program. A medical staff member is responsible for each patient's treatment and a psychiatric nurse manager is responsible for program administration. Patients are assigned to a treatment program based on their needs and level of functioning. The remainder of this section provides a brief overview of each treatment program. The average daily census for each unit is displayed in Table 10.

TREATMENT PROGRAM SUMMARY

At the present time, Arizona State Hospital is organized by programs as follows:

PROGRAMS	NUMBER OF UNITS
SPECIALITY PROGRAMS	
Adolescent Treatment Unit	one
Early Discharge Unit	two
Kachina 1	
Kachina 2	
Transitional Living Unit (TLU)	two cottages
Forensic/Behavior Management Unit	two
Cholla	
Juniper 1*	
PSYCHOSOCIAL REHAB PROGRAM	five
Granada West 1	
Juniper 3	
Juniper 6 (Level B)	
Juniper 8 (Level C)	
Juniper 10	
CONTINUED CARE PROGRAM	five
Juniper 2	
Juniper 4	
Juniper 7	
Juniper 9	
Granada	

*Juniper 1 was a PsychoSocial Rehabilitation Unit at the beginning of FY 1985-1986. In January, 1986, Juniper 1 was designated as a forensic unit for female patients.

SPECIALITY PROGRAMS

RECEPTION CENTER

HOURS - 8:00 AM to 5:00 PM, Monday through Friday (by appointment, whenever possible)

PURPOSE

Intensive screening to evaluate, admit, and assign patients to the appropriate treatment unit.

ADMISSION

Occurs per Arizona State Hospital policies and procedures. When possible, pre-admission evaluations will be completed prior to the patient's arriving at the Reception Center.

EVALUATION

Includes psychiatric, social service and nursing assessments.

EARLY DISCHARGE - KACHINA 1

RECOMMENDED CENSUS -43

PURPOSE

Provide intensive evaluation and treatment services to patients generally ready to be discharged within 90 days. The primary focus is to resolve problems causing admission.

ADMISSION

Admission to the unit is the joint decision of the admitting psychiatrist and the psychiatrist of the unit. The psychiatrists determine the ability of the unit program to meet each patient's specific needs.

EVALUATION

As ordered by the attending physician, comprehensive evaluations may be performed by all disciplines as a coordinated interdisciplinary team.

DISCHARGE

The decision to discharge a patient will be made by the attending physician, based on the patient's progress relative to the goals and objectives of the patient's treatment plan and ability to live in the least restrictive setting.

TRANSFER

Patients may be transferred by authority of the short-term lead psychiatrist to a more appropriate unit, and this can occur at any time it is determined the patient cannot be discharged within 90 days.

MAJOR TREATMENT MODALITIES

Psychotropic medication; psychotherapy focusing on compliance with medication, reasons for admission, specific discharge plans and goals; rehabilitation patient education; intensive liaison for community re-integration and aftercare treatment; leisure and recreational activities; structured milieu activities; physical care/hygiene, and reality focusing.

EARLY DISCHARGE - KACHINA 2

RECOMMENDED CENSUS - 43

PURPOSE

Provide intensive evaluation and treatment services to patients expected to be ready for discharge within 90 days. The primary focus is to resolve problems causing admission.

ADMISSION

Direct admissions from the community.

EVALUATION

Comprehensive evaluations may be done by all disciplines, as needed, as a coordinated interdisciplinary team.

DISCHARGE

The decision to discharge a patient will be made by the attending physician and based on the patient's progress relative to the goals and objectives of the patients treatment plan and ability to live in the least restrictive setting.

TRANSFER

Patients shall be transferred by authority of the short-term lead psychiatrist to another unit. This can occur at any time it is determined that the patient cannot be discharged within 90 days.

MAJOR TREATMENT MODALITIES

Psychotropic medications; psychotherapy focusing on compliance with medication, reasons for admission, specific discharge plans and goals; rehabilitation patient education; intensive liaison for community re-integration and aftercare treatment; leisure and recreational activities; structured milieu activities; physical care/hygiene; and reality focusing.

TRANSITIONAL LIVING PROGRAM

RECOMMENDED CENSUS - 6 Males/6 Females

PURPOSE

To provide a treatment program that bridges the chronically mentally ill client

between the inpatient unit and the community placement, be it independent or a supportive care facility. Patients are generally ready to be discharged within six months.

ADMISSION

Admission to the unit is the decision of the unit physician and is limited to patients who are age 18 or older; voluntary, gravely disabled or dangerous to self.

EVALUATION

On written referral to the Transitional Living Program or through the unit liaison, evaluation will be completed on the unit and the patient presented to the screening team.

DISCHARGE

On completion of the goals established for each patient as part of his treatment plan.

TRANSFER

Transfer will occur if patient's behavior presents a hazard to himself or others, or is seriously disruptive to the program. In cases where these criteria do not apply but the patient cannot be discharged from the Hospital as planned, referring treatment unit agrees to arrange transfer within two weeks of notification.

MAJOR TREATMENT MODALITIES

Treatment focuses on community orientation and linking patients into a network of community supports; individual, group and family counseling are also provided in the program.

ADOLESCENT TREATMENT UNIT

RECOMMENDED CENSUS - 22

PURPOSE

To provide a comprehensive multi-disciplinary therapeutic program for adolescents with substantial psychiatric disorders, assisting them to develop and maintain their highest level of adaptability. Patients are generally ready for discharge in three to twelve months.

ADMISSION

Ages 12 through 17 years; meets Arizona State Hospital criteria for voluntary admission or court-ordered treatment; is unable to benefit from outpatient care, as demonstrated by previous evaluation and/or treatment; is unable to benefit from non-hospital therapeutic setting, such as residential treatment facility or therapeutic foster home, as demonstrated by previous evaluation and/or treatment; has been referred by an officially involved care agency,

mental health agency, or private practitioner in mental health; after thorough screening based on previous evaluations and/or reports of treatment, clearly requires an intermediate-term, psychiatric inpatient hospitalization, lasting approximately 3 to 12 months; suffers from a substantial psychiatric disorder of adolescence in accordance with DSM-III criteria; does not suffer from an acute medical condition requiring skilled medical and nursing care, which more appropriately should be handled in a general hospital setting; does not suffer from moderate-to-severe mental retardation; does not suffer from mild mental retardation, which is clearly the primary condition requiring attention or treatment.

EVALUATION

As ordered by the attending physician, evaluation or assessments are provided by all disciplines and appropriate therapies provided by the interdisciplinary team.

DISCHARGE

When behavioral goals as outlined in the individual's treatment plan are attained and community living arrangements are completed.

TRANSFER

Not within the Arizona State Hospital - - unless 18 years of age.

MAJOR TREATMENT MODALITIES

Education; rehabilitation, occupational, recreational, speech and hearing; milieu therapy; individual, group and family therapy.

BEHAVIOR MANAGEMENT PROGRAM

BEHAVIOR MANAGEMENT UNIT I - CHOLLA

RECOMMENDED CENSUS - 44

PURPOSE

To provide evaluation, treatment and behavior modification for patients who, because of legal status or behavior problems, need placement in a locked, secure facility. Patients transferred to the unit to treat behavior management problems remain until all violent/explosive behaviors have been extinguished for at least a thirty day period.

ADMISSION

Direct admission from County and State correctional institutions, direct admissions from the community and admissions/transfers from other on-ground hospital units.

EVALUATION

Comprehensive evaluations may be done by all disciplines as needed and as a

coordinated interdisciplinary team.

DISCHARGE

Discharge occurs with coordination within the criminal justice system, guardians, community health agencies and families and is based on the attainment of behavioral goals outlined in the individual's treatment plan.

TRANSFER

For those patients committed as a danger to others, transfer to a less restrictive unit occurs after a second-level review has established that the patient has exhibited no violent/assaultive behaviors for at least the last 30 days. All other patients are transferred by the authority of the unit psychiatrist when behavior is no longer considered a major treatment problem and when space is available on a less restrictive unit.

MAJOR TREATMENT MODALITIES

Psychotropic medication; psychotherapy focusing on compliance with medication, reasons for admission, specific discharge plans and goals; rehabilitation patient education; intensive liaison for community re-integration and aftercare treatment; leisure and recreational activities; structured milieu activities; physical care/hygiene, reality focusing and behavior modification.

BEHAVIOR MANAGEMENT - JUNIPER 1

RECOMMENDED CENSUS - 24

PURPOSE

To provide a structured safe, secured unit for female patients with an emphasis on therapeutic programming to assist in meeting the individual needs.

ADMISSION

A. Legal Holds
   1. Rule 11 observation
   2. Rule 11 treatment
   3. Voluntary admission from jails
   4. Females unable to be treated at Department of Corrections
   5. Committed under ARS 13-3994 (NGRI)
   6. Civil commitments with detainer

B. Behavioral Problems
   1. Acutely disturbed and assaultive females
   2. Recent treatment of notably dangerous behavior (murder, assault and severe injury to victim, child molester, rapist, arsonist)
   3. Persistent runaway from other closed units if behavior in society is dangerous.

EVALUATION

Comprehensive evaluations may be done by all disciplines as needed and as a coordinated interdisciplinary team.

DISCHARGE

Discharge occurs with coordination among the criminal justice system, guardians, community health agencies and families and is based on the attainment of behavioral goals outlined in the individual's treatment plan.

TRANSFER

Patients within the Hospital who are behavior management problems will be transferred into Behavioral Management with the agreement that upon stabilization of the acute behavior problem they will return to the unit of origin. Patients on J-1 will be transferred out when treatment goals have been reached.

MAJOR TREATMENT MODALITIES

Psychotropic medication; psychotherapy; occupational therapy; recreational therapy; adult education; nursing services including self medication, self care, and government; highly structured secure milieu; individualized behavior modification plans.

PSYCHOSOCIAL REHABILITATION PROGRAM (PSR)

PSR - GRANADA WEST

RECOMMENDED CENSUS - 24

PURPOSE

This program of pre-community care through Psychosocial Rehabilitation provides brief residential care with comprehensive therapeutic programming that encourages independence and active participation in community-based programs and prepares the patient for early discharge from the Hospital. Granada West is an open unit.

ADMISSION

Age 18 or older; goal attainment score 50 and above; completes activities of daily living with minimal supervision; attends activities and participates.

EVALUATION

Comprehensive evaluations may be done by all disciplines, as ordered by the attending psychiatrist, as a coordinated interdisciplinary team.

DISCHARGE

A patient will be discharged when goals outlined in the patient's treatment plan are met.

TRANSFER

Patients that do not meet criteria and require longer term treatment will be transferred to another PSR level program.

MAJOR TREATMENT MODALITIES

Psychotropic medications; psychotherapy to develop insight into reasons for admission; occupational therapy, recreational therapy; adult education; nursing services, including self-medication program; self-care; patient government and discharge planning program.

PSR - JUNIPER 3

RECOMMENDED CENSUS - 28

PURPOSE

To provide a safe therapeutic environment for those patients 55 years of age, or older, who will be prepared for discharge to the community within six months.

ADMISSION

Criteria for admission include: 55 years of age or older; ambulatory; continent; verbal; able to function on an open unit without risk of unauthorized absence.

EVALUATION

As ordered by the attending physician, evaluations and assessments are performed by all disciplines and appropriate therapies are provided by the interdisciplinary treatment team.

DISCHARGE

Discharge is ordered by the attending physician when the patient achieves behavioral goals outlined in the patient's treatment plan and can live in a less restrictive environment.

TRANSFER

Appropriate patients are accepted as transfers from other units and are transferred as their physical or behavioral condition changes. Decisions to transfer patients are made by the unit physician involved.

MAJOR TREATMENT MODALITIES

Psychotropic medications; group dynamics; occupational therapy; recreational therapy and psychology are examples of groups offered on the unit; self-medication, self-care, reminiscent groups, community orientation, current events, community meetings, individual treatment programs, as needed; physical therapy, art and music therapy, cooking and nutrition, gardening, individual counseling and other therapeutic activities, reality orientation.

PSR - JUNIPER 6 (LEVEL B)

RECOMMENDED CENSUS - 24

PURPOSE

J-6 is the Level B program for pre-community care through Psychosocial Rehabilitation. Residential care is provided for those patients that require supervision and direction in assuming responsibility for advancement to Level A and/or discharge. Patients generally require treatment for up to one year.

ADMISSION

Criteria for admission include: Age 18 or older; goal attainment score between 41-50; requires verbal prompting to complete activities of daily living.

EVALUATION

As ordered by the attending physician, comprehensive evaluations and assessments may be performed by all disciplines and therapies provided by members of the interdisciplinary treatment team.

DISCHARGE

It is the unit goal for Level B patients to be motivated to achieve a higher level placement, then be discharged from the hospital; however, a patient can be discharged directly from J-6 when he attains behavioral goals outlined in his treatment plan and can be placed in a less restrictive setting in the community.

TRANSFER

Patients that do not meet the criteria for the Level B program will be transferred to the appropriate level program within PSR or to other hospital units by the joint decision of the unit psychiatrists involved.

MAJOR TREATMENT MODALITIES

Psychotropic medications; psychotherapy; occupational therapy; recreational therapy; special physical therapy; adult education; nursing services, including self-care, patient government and discharge planning program.

PSR - JUNIPER 8 (LEVEL C)

RECOMMENDED CENSUS - 24

PURPOSE

J-8 is the Level C program of pre-community care through the Psychosocial Rehabilitation unit. Long term care is given to provide a structured therapeutic milieu for patients who require supervision and direction in the performance of activities of daily living and the development of basic behavioral and social skills that are required to function in a less restrictive setting.

ADMISSION

Criteria for admission include: males/females age 18 or older; goal attainment score between 21-40; requires extensive supervision to complete activities of daily living; interactions with others need to be closely monitored and the program should be highly structured.

EVALUATION

As ordered by the attending physician, comprehensive evaluations and assessments will be provided by all disciplines and suggested therapies provided by members of the interdisciplinary treatment team.

DISCHARGE

The decision to discharge a patient is made by the attending physician based on the patient's attainment of behavioral goals outlined in the patient's treatment plan and ability to live in a less restrictive environment in a community setting.

TRANSFER

Transfers will occur when it is determined by the attending physician that a patient is no longer appropriate for the programs provided on J-8 and can benefit from the services on another hospital unit.

MAJOR TREATMENT MODALITIES

Structured therapeutic community; psychotherapy groups; individual therapy; psychotropic medication; patient and family education; leisure and recreational activities; structured milieu; reality orientation and activities of daily living training.

PSR - JUNIPER 10

RECOMMENDED CENSUS - 40

PURPOSE

The program for J-10 treats patients who generally receive care over a six-month period. Patients are provided an intensive inpatient rehabilitation program with a high degree of environmental security for individuals with maladaptive social behavior and intrapsychic distress of a chronic nature.

ADMISSION

Criteria for admission include: males/females; court commitment as danger to others; high risk/high profile or unauthorized absence risk; need for locked, moderately secure unit.

EVALUATION

As ordered by the attending physician, evaluations and assessments will be provided by all disciplines and appropriate therapies provided by members of

the interdisciplinary treatment team.

DISCHARGE

Discharge will occur when the patient is no longer considered high risk/high profile or dangerous to others and achieves behavioral goals as outlined in the patient's treatment plan.

TRANSFER

Patients who require additional treatment but are no longer considered dangerous to others, high risk/high profile or unauthorized absence risk will be transferred to another unit.

MAJOR TREATMENT MODALITIES

Psychotherapy; therapeutic community; individual therapy focusing on reason for admission, specific discharge plans; goals for hospitalization; psychotropic medication; patient and family education; leisure and recreational activities; structured milieu; activities of daily living training; and reality orientation.

CONTINUED CARE PROGRAM (CCP)

CCP - JUNIPER 2

RECOMMENDED CENSUS - 24

PURPOSE

To provide a safe, therapeutic environment for 24 male patients who exhibit severely regressed behavior and indicate need for highly structured programs; are not amenable to insight-oriented therapies. These patients require daily planned programs, rehabilitative activities and nursing and physical care over a long period of time.

ADMISSION

Criteria for admission to J-2 is based on the following requisites: male; 40 to 70 years of age; no major acute medical problems, i.e. requiring tube feedings, oxygen, IV's; ambulatory; behavior is influenced by either delusions or hallucinations; impaired communication; unable to function in open environment; needs supervision or assistance to maintain personal hygiene; physically attacks others with intent to harm; self-abusive.

EVALUATION

Evaluations for admission, transfer, and discharge are conducted by the attending physicians. When ordered by the attending physician, evaluations and assessments are provided by all disciplines and appropriate therapies are provided by members of the interdisciplinary treatment team.

DISCHARGE

Attending physicians will discharge patients directly from J-2 when they attain

the behavioral goals outlined in their individual treatment plans and are appropriate for structured supervisory or nursing home care.

TRANSFER

Transfer of a patient to another unit is by decision of unit psychiatrist with consultation of nursing staff. Reasons for transfer may be: development of medical problems requiring intensive nursing care; regression in mental functioning that markedly affects their three spheres of orientation: name, place, time. In addition, mental regression of patients is such that they need closer supervision to protect from injury to self and being injured by others.

MAJOR TREATMENT MODALITIES

Medication; adult education program; reality orientation group; current events group; structured ward activities; leisure and recreational activities; ward recreational activities.

CCP - JUNIPER 4

RECOMMENDED CENSUS - 24

PURPOSE

To provide a safe, therapeutic environment for 24 female patients who exhibit moderate-to-severely regressed behavior and indicate need for highly structured programs who are not amenable to insight-oriented therapies. These patients require daily planned programs, rehabilitative activities and nursing and physical care over a long time period.

ADMISSION

Criteria for admission to J-4 is based on the following requisites: female; 35 to 65 years of age; no major acute medical problems; ambulatory; behavior is influenced by either delusions or hallucinations; impairment in functioning in several areas; needs supervision or assistance to maintain personal hygiene; physically attacks others with intent to harm; self-abusive.

EVALUATION

Evaluations for admission, transfer, and discharge are conducted by attending physicians. When ordered by the attending physician, evaluations and assessments are provided by all disciplines and appropriate therapies are provided by members of the interdisciplinary treatment team.

DISCHARGE

Physicians shall discharge patients directly from J-4 when they attain the behavioral goals outlined in their individual treatment plans and are appropriate for boarding home, structured supervisory or nursing home care.

TRANSFER

Transfer of a patient to another unit is by decision of unit psychiatrist with consultation of nursing staff. Reasons for transfer may be: development of

medical problems requiring intensive nursing care, regression in mental functioning that markedly affects their three spheres of orientation. In addition, mental regression of patients is such that they need closer supervision to protect from injury to self and being injured by others.

MAJOR TREATMENT MODALITIES

Medication; adult education; reality orientation group; structured ward activities; leisure and recreational activities; ward recreational activities.

CCP - JUNIPER 7

RECOMMENDED CENSUS - 28

PURPOSE

To provide a safe therapeutic environment for patients who, because of the severity of their mental and physical disabilities, require continuous observation and supervision. Most of these patients suffer from organic brain failure and are dependent for nursing care, planned programs, rehabilitative activities and frequent psychiatric and medical care and require care over a long period of time.

ADMISSION

Criteria for admission include: patients are 55 years of age and older; male or female; ambulatory/wheelchair/geri-chair; no major acute medical problem; require extensive assistance in self-care; require physical support for self-protection; Gas Score 5 or under.

EVALUATION

As ordered by the attending physician, comprehensive evaluations and assessments are provided by all disciplines and appropriate therapy provided by members of the interdisciplinary treatment team.

DISCHARGE

Discharge occurs with coordination of Maricopa County Long-Term Care placement, guardians, community health agencies, families and the Department of Economic Security, Division of Developmental Disabilities and is based on the attainment of behavioral goals outlined in the patient's treatment plan and the ability of the patient to live in a less restrictive setting in the community.

TRANSFER

Patients are at the lowest cognitive functioning level, therefore, transfers are rare except to Granada or outside facilities for the treatment of a medical condition.

MAJOR TREATMENT MODALITIES

Chemotherapy; structured milieu activities; sensory stimulation; reality orientation; recreational activities; physical therapy; personal care/hygiene.

CCP - JUNIPER 9

RECOMMENDED CENSUS - 45

PURPOSE

To provide a safe therapeutic environment for patients who, because of the severity of their mental and physical disabilities, cannot function in other treatment units. Secondary to their organicity, these patients require daily planned programs and rehabilitative activities, nursing care, frequent psychiatric and medical consultations and require care over a long period of time.

ADMISSION

Admission criteria include: patients are 55 years of age and older; male or female; ambulatory/wheelchair/geri-chair; no major acute medical problems. May require physical support for self-protection. Usually responsive to simple directions. Gas Score 15 or under.

EVALUATION

As ordered by the attending physician, comprehensive evaluations and assessments are provided by all disciplines and appropriate therapies are provided by members of the interdisciplinary treatment team.

DISCHARGE

Discharge occurs with coordination of Maricopa County Long Term Care placement, guardians, community health agencies, families and the Department of Economic Security, Division of Developmental Disabilities and is based on the attainment of behavioral goals outlined in the patient's treatment plan and the ability of the patient to live in a less restrictive setting in the community.

TRANSFER

Transfers occur when the patient is no longer appropriate for the programs provided on J-9 or when the patient requires definitive medical care on Granada or other outside treatment facilities.

MAJOR TREATMENT MODALITIES

Chemotherapy; structured milieu activities; sensory stimulation; reality orientation; behavior modification; community and family reintegration; leisure and recreational activities; specific discharge plans and aftercare; physical therapy; physical care/hygiene and social skills activities.

CCP - GRANADA

RECOMMENDED CENSUS - 43

PURPOSE

To provide a safe and therapeutic environment for those patients who require

medical care, total supportive nursing care and continue to exhibit behaviors that require psychiatric consultation. Granada also provides short term medical care for patients temporarily boarding from other units for care of acute medical problems (eq. pneumonia, post surgical care, infections).

ADMISSION

Admission criteria include the need for total supportive nursing care. The attending physician and medical officer of Granada will determine the appropriateness of each admission to Granada.

EVALUATION

When a psychiatric evaluation is needed, a consulation is requested of a unit psychiatrist by the medical officer.

DISCHARGE

Whenever behaviors as outlined in the patients treatment plan have stabilized and appropriate arrangements can be made to place the patient in an appropriate community facility or return the patient to a family setting.

TRANSFER

When the patient meets the criteria for a treatment unit.

MAJOR TREATMENT MODALITIES

Specialized treatment, such as oxygen therapy, IV therapy, isolation techniques, techniques, rehabilitation, recreational activities, physical therapy, psychotropic medications, medical treatment, structured milieu activities, reality orientation, structured mobilization program and total physical and mental care of patient.

TREATMENT METHODS

Psychiatric

Biological Therapy (medications):

A. Neuroleptic/psychotropic pharmaceuticals for patients manifesting psychotic states/symptoms;

B. Lithium for patients manifesting manic states/symptoms -- essentially bipolar type, but also schizoaffective types;

C. Antidepressant pharmaceuticals for major depressions;

D. Occasionally, electric shock therapy for patients with depression who have been unresponsive to other types of treatment; and

E. Antiseizure pharmaceuticals for convulsive disorders.

Psychotherapy

A. Individual psychotherapy by professional psychiatric and psychological staff and therapy by social workers and nurses; supportive, crisis-oriented and insight psychotherapy, when indicated; and individual counseling by paraprofessional staff regarding problems of daily living;

B. Behavior modification conducted by Ph.D. psychology staff to improve control of difficult behavior and develop desired behavior;

C. Group therapy for enhancement of interpersonal relations; and

D. Assertive training to improve self-care skills and enhance self-interest and reality orientation.

Environmental Control

A. Close observation in secured, controlled setting to protect against self-destructive behavior or control behavior that is dangerous toward others; and

B. Safe and supportive environment to reduce or negate socioeconomic stressors.

Rehabilitation Therapy

A. Occupational therapy to assist regressed patients in increasing sense of reality, improving attention span and task attendance, and improving level of frustration tolerance. Occupational therapy also assists inpatients who have sufficiently recovered to develop skills that may be marketed after discharge by improving and maintaining sense of self-worth and increased responsibility for self, thereby increasing likelihood of better outpatient adjustment;

B. Recreation therapy to enhance social interaction, discharge excess energy through physical activities, and to reduce tedium of hospitalization;

C. Physical therapy to treat physical problems of chronic patients suffering spasticity, joint immobility, and breakdown of superficial tissue. Physical therapy also functions to improve strength and to increase the mobility of patients; and

D. Speech, Language and Hearing Therapy to improve the communicative skills of patients through assessment of ability to receive and transmit spoken messages and the implementation of remedial programming.

Nursing Services

Twenty-four hour implementation of interdisciplinary treatment plans, and provision of patient supervision, medical and psychiatric nursing care, supportive and therapeutic interventions, and therapeutic milieu.

TABLE 10

ARIZONA STATE HOSPITAL
AVERAGE DAILY CENSUS BY TREATMENT UNIT
FY 1984-1985 AND FY 1985-1986

Month	PSR	EDU	ATU	BMU	CCP	TLU	TOTAL
1985							
July	168	56	16	53	183	8	484
August	153	61	15	53	174	9	465
September	155	66	16	57	167	9	470
October	155	72	18	48	164	9	466
November	162	77	22	47	166	10	484
December	167	80	23	48	168	10	496
1986							
January	168	76	19	63	168	10	504
February	168	76	18	65	169	10	506
March	168	85	17	67	172	9	518
April	170	80	22	61	176	10	519
May	162	70	20	64	174	10	500
June	160	72	17	60	172	10	492
MTHLY AVG	**163**	**73**	**19**	**58**	**171**	**10**	**492**
1984							
July	154	60	19	52	171		456
August	158	63	18	55	173		466
September	159	51	20	56	176	4	464
October	162	55	21	57	178	6	478
November	167	52	21	58	181	8	488
December	167	55	20	59	184	9	493
1985							
January	164	57	21	60	182	7	496
February	166	58	22	56	187	6	496
March	169	57	21	57	193	8	502
April	171	54	19	56	190	7	497
May	170	54	19	55	188	7	493
June	167	61	19	56	184	7	493
MTHLY AVG	**164**	**56**	**20**	**57**	**174**	**6**	**485**

PERSONNEL

Arizona State Hospital improved its turnover and vacancy rates during FY 1985-1986 while expanding its staff. The turnover rate at the Arizona State Hospital for FY 1985-1986 was approximately 25%, the same as the Department of Health Services. This is an improvement from FY 1984-1985's rate of 30% and may be attributed to several factors. One factor which may have affected the turnover rate is the change from the crediting of compensatory time for overtime to the payment of overtime. Arizona State Hospital also reduced its vacancy rate from 26% for FY 1984-1985 to a manageable 9%. This was accomplished through an aggressive recruitment program and improved efficiency in the hiring procedures. The number of employees working at Arizona State Hospital increased from 720.75 to 820.75.

TABLE 11

ARIZONA STATE HOSPITAL
TOTAL FULL TIME EQUIVALENTS (FTE)
JUNE 30, 1986

Direct Services Staff	
Psych Nurse Treatment Unit Manager	8.0
Psych Nurse	59.0
Psych Nurse Director	1.0
Psych Nurse Assistant Director	1.0
Psych Treatment Unit Coordinator	8.0
Psych LPN II	14.0
Therapists	24.0
Teachers	8.0
Psychologists	9.0
Psychology Intern	2.0
Social Workers	28.0
Psychiatric Technician III	51.5
Psychiatric Technician II	95.0
Psychiatric Technician I	108.0
Behavioral Health Rehab II	2.0
Medical Records	28.0
Psych Nurse Instructor	2.0
Librarians	2.0
Dentists	3.0
Pharmacy	7.0
Laboratory	5.5
X-Ray	2.0
Behav. Health Treatment Unit Manager	1.0
Beautician	1.0
Life Guard	.25
Podiatrist	.50
Chaplain	2.0
Barber	1.0
DHS Attorney III	1.0
Research and Stat	1.0
Psych Nurse Shift Supervisor	31.0
Psych Nurse Ward Supervisor	15.0
Psych Nurse Technician II	28.0
Therapy Technician	20.0
Psych Technician IV	6.0
	575.75

Support Staff	
Superintendent	1.0
Admin. Services Officer III	1.0
Physical Plant Director	1.0
Finance	6.0
Clerical	37.0
Administrative Assistant	9.0
Clerk (Diet)	4.0
Custodial Workers	46.0
Building Maintenance Supervisor	2.0
Maintenance	26.0
Groundskeeper	5.0
Laundry	12.0
Training Officer	2.0
Laborer	3.0
Custodial Supervisor	5.0
Food Service Director	1.0
Dietitians	2.0
Food Supervisor	6.0
Cooks	7.0
Food Service Worker	26.0
Messenger Delivery Driver	6.0
Security Officer	16.0
Switchboard Operators	5.0
Sewing Supervisor	2.0
Quality Assurance Manager	1.0
Patients' Rights Representative	1.0
Research, Stat Analyst	2.0
Volunteer Services Coordinator	1.0
Administrative Services Officer II	1.0
Quality Assurance Analyst	2.0
Program and Project Specialist II	4.0
Executive Staff Assistant	1.0
Clinical Director	1.0
	245.0

TOTAL **820.75**

There were approximately eleven psychiatrists and four and one half medical physicians on contract with the Arizona State Hospital during this period. These positions are not included in the FTE total.

ARIZONA STATE HOSPITAL
FINANCIAL SUMMARY
FY 1985-1986

Funding Sources (General Operations):	
State General Fund Appropriations (net)	
Personal Services and Related Benefits	$18,276,461
Operating Expenses	4,392,474
Rental Income	644,236
Endowment Earnings	34,596
Patient Benefit Fund	99,300
Donations	996
Total Funding	**$23,448,063**
Expenditures:	
Personal Services and Related Benefits	$18,300,227
* Professional and Outside Services	2,013,443
Travel (In-State)	31,551
Travel (Out-of-State)	3,524
Food	741,191
Other Operating	2,284,497
Capital Equipment	73,630
Total Cost of Operations	**$23,448,063**
Collections (Deposited to the General Fund):	
Medicare	$1,601,954
Family, Guardian, or Patient	603,967
Insurance	302,368
Counties - Rule 11	145,842
Social Security, VA, or Railroad Retirement	229,000
Military Service Connected Neuropsychiatric	30,175
Total	**$2,913,306**
Daily Costs by Treatment Unit	
Admissions and Evaluation	$201.00
Behavioral Management	$152.00
Adolescent Treatment	$241.00
Psycho-Social Rehabilitation	$131.00
Continued Care	$122.00
Transitional Living	$183.00
Average	$146.00

* Contract Physicians, Nursing Registries, Outside Hospitalization Costs

THE PHYSICAL PLANT

Arizona State Hospital is an antiquated physical plant. Roadways and streets on the grounds need restoration and improvement; many pavement areas need to be replaced to eliminate hazardous conditions.

The original galvanized pipes and temperature control valves within the Hospital buildings have deteriorated over the years to the extent that water temperature controls in showers and sinks cannot be properly adjusted.

The central cooling system that serves the Juniper Complex, Kachina, Administration Building and Encanto requires increased maintenance and upkeep on the utility tunnels is costly, justifying development of an alternative cooling system. Individual units are recommended because they could cut down maintenance costs and equipment malfunction.

Although most equipment throughout ASH is in fair-to-good condition, major pieces of equipment in the Hospital laundry facility are over 20 years old; some parts are either obsolete, unreliable or no longer available. (Approximately 1.5 million pounds of laundry are processed yearly.)

Hospital staff has also identified numerous areas on campus that are not accessible or safe for handicapped patients or staff members who must use wheelchairs, crutches, walkers, or are visually impaired. Some bathrooms are inaccessible; ramps and doorways are inadequate. Budget requests were submitted to make renovations for the handicapped. ASH engineering staff subsequently enlarged the bathrooms on Juniper 5, Juniper 9 and Juniper 10 to improve accessibility.

Proposed improvements for the physical plant are included in the section of this report titled "Recommendations."

RECOMMENDATIONS

Administrative/Clinical

The Arizona State Hospital should take a leadership role in the creation of a Children's Program at the Hospital. Research into the feasibility of this project began with the development of a budget request and a more coordinated effort will continue.

Conversion of the contracted physicians who have been appointed as Treatment Program Medical Directors to the status of state employees would effect better management of treatment program personnel and improved accountability for supervision and quality of services provided. A budget request for this conversion has been submitted.

Arizona State Hospital must determine the appropriate action to be taken to resolve the problems associated with the deterioration of the laundry equipment. The present equipment has deteriorated to the point where the ability to provide laundry services is jeopardized. The alternatives for the solution to the problem include modernization of equipment or contracting for services. A report submitted by a consulting firm, Foussard Econlab, will be used as a basis for the final decision.

A continued effort toward the development of a psychiatric residency program should be a priority. Liaisons with universities and other psychiatric residency training programs should be strengthened to improve the Hospital's involvement in the academic community and to facilitate university involvement in direct services at the Hospital.

Approximately 30 to 50 patients at Arizona State Hospital could be well cared for in a psychiatric nursing home if such a facility was available. The space vacated by these patients could then be used to provide service to patients who could better benefit from the Hospital's therapeutic programs. This would result in a more effective use of Hospital resources. However, there are no nursing homes in the Valley at this time which could qualify as psychiatric nursing homes. The issue of financial responsibility for

patients discharged from Arizona State Hospital is currently being explored with County systems.

Physical Plant

Building renovations are continually in progress. A list of proposed building renovations is found in Table 12. However, the development of a long range plan is recommended to assist the administration in setting priorities for building renewal and capital improvement. An architect should be contracted to do a survey of the physical plant. The need for a study and plan is evident by the deterioration of the physical facilities. Many buildings presently in use were not designed for the purposes they now serve and a number require either extensive remodeling or demolition.

The roads on the Hospital grounds are in deplorable condition. Pavement areas have become quite unsafe due to continued neglect and breakdown of existing grade. Additional heavy traffic from DOC has added to the rapid deterioration.

It is recommended that renovation of the roads be divided into two phases. Phase One includes renovation to the following streets: from the Garage to E-Street to the service entrance of Juniper Building, approximately 90,000 square feet; from the Warehouse to Security Gate to Commmissary, approximately 32,000 square feet; and remove existing asphalt, improve base course to support drainage, install curbs as require and install 4" of asphalt. Phase Two would involve the following streets: from west of Dietary to Power Plant, approximately 35,000 square feet; from south of Education to Aspen, approximately 11,000 square feet; and from south of Juniper to east of Granada, approximately 8,000 square feet.

Plans to make Arizona State Hospital more accessible for the physical handicapped should be implemented in FY 1986-1987. Funding for these plans has been allocated by the State Legislature.

TABLE 12

RECOMMENDATIONS FOR REMODELING/ CONSTRUCTION PROJECTS

Projects to be conducted by the Engineering Department:

1. Power Plant
   - Retrofitting existing boilers with efficient burners.
   - Rebuilding or replacing boilers.
   - Heating and air conditioning pumps modification and pump installation.
   - Installation of circulating water pump and rearranging piping.
   - Funds requested for FY 1987-1988.

2. Birch Building
   - Replace refrigeration compressors.
   - Remove old compressors and install new high efficient units.
   - Funds requested for FY 1987-1988.

3. Kachina Building
   - Air conditioning system remodeling.
   - Installation of new air conditioning system and removal of old units.
   - Funds requested for FY 1987-1988.

4. Hermosa Building
   - Exterior repairs of roof and walls.
   - Interior remodeling of major efforts; ceiling replacement, wall partition modification.
   - Electrical distribution system upgrading and lighting improvement.

5. Transitional Living Cottages
   - Replace refrigeration.

6. Cholla Building
   - Implement plans to improve the safety of the building in the event of fire.
   - Project should be completed in FY 1986-1987.

7. Roof Repairing
   - All buildings will require minor and major roof repairs within the next two